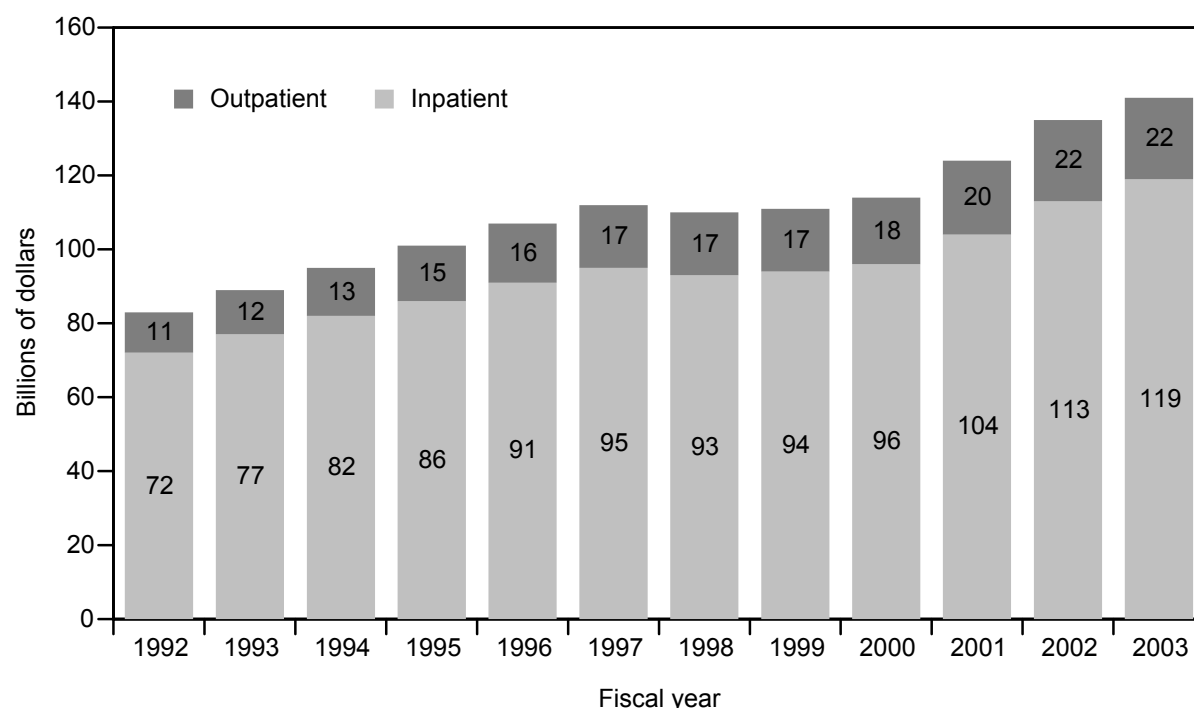


SECTION

8

Acute inpatient services
Short-term hospitals
Specialty psychiatric facilities

Chart 8-1. Medicare's hospital inpatient and outpatient spending, fiscal years 1992–2003



Note: Includes inpatient services covered by the acute inpatient prospective payment system (PPS) and psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; includes outpatient services covered by the PPS and other outpatient services. Payments include both program outlays and cost sharing incurred by beneficiaries.

Source: CMS, Office of the Actuary.

- Medicare hospital inpatient spending increased 65 percent (4.7 percent per year), and outpatient spending increased 100 percent (6.5 percent per year) from fiscal year (FY) 1992 to FY 2003. A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA), combined with lower Medicare discharges, reduced inpatient spending in 1998. An increase in Medicare discharges, larger updates, case mix change, and expansion of disproportionate share hospital payments contributed to increased inpatient spending in 2001 and 2002. In 2003, slower Medicare discharge growth and slower case mix change led to moderation in inpatient spending growth.
- Outpatient spending fell in 1998, reflecting the BBA's elimination of inadvertent overpayments. Transitional corridor and new technology payments in the outpatient prospective payment system, along with volume growth, increased outpatient spending in 2001 and 2002. Slower volume growth and changes in pass-through payments led to a smaller spending increase in 2003.
- In FY 2003, aggregate Medicare inpatient spending was \$119 billion and outpatient spending was \$22 billion.

Chart 8-2. Diagnosis related groups with highest volume, fiscal year 2004

DRG number	DRG name	Percentage of discharges	Number of discharges (thousands)
127	Heart failure and shock	6%	696
89	Simple pneumonia and pleurisy age > 17 with cc	5	551
209	Major joint and limb reattachment procedures of lower extremity	4	461
88	Chronic obstructive pulmonary disease	3	414
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age > 17 with cc	2	292
296	Nutritional and miscellaneous metabolic disorders age > 17 with cc	2	255
174	GI hemorrhage with cc	2	268
143	Chest pain	2	249
14	Intracranial hemorrhage or stroke with infarct	2	237
320	Kidney and urinary tract infections age > 17 with cc	2	219
Total Medicare discharges		100	12,140

Note: DRG (diagnosis related group), cc (complication or comorbidity), GI (gastrointestinal).

Source: Federal Register, May 4, 2005, pp. 23,614–23,620. Available at www.gpoaccess.gov/fr/index.html. Based on FY 2004 MedPAR (December 2004 update, Grouper version 22 FY 2005).

- In fiscal year 2005, Medicare inpatient cases are assigned to 522 DRGs based on discharge diagnoses, procedures performed, age, sex, discharge destination, and presence of complications or comorbidities.
- In fiscal year 2004, 10 diagnosis related groups (DRGs) accounted for 30 percent of discharges from hospitals paid under the acute inpatient prospective payment system.

Chart 8-3. Number of hospitals and Medicare discharges, by hospital group, 2003

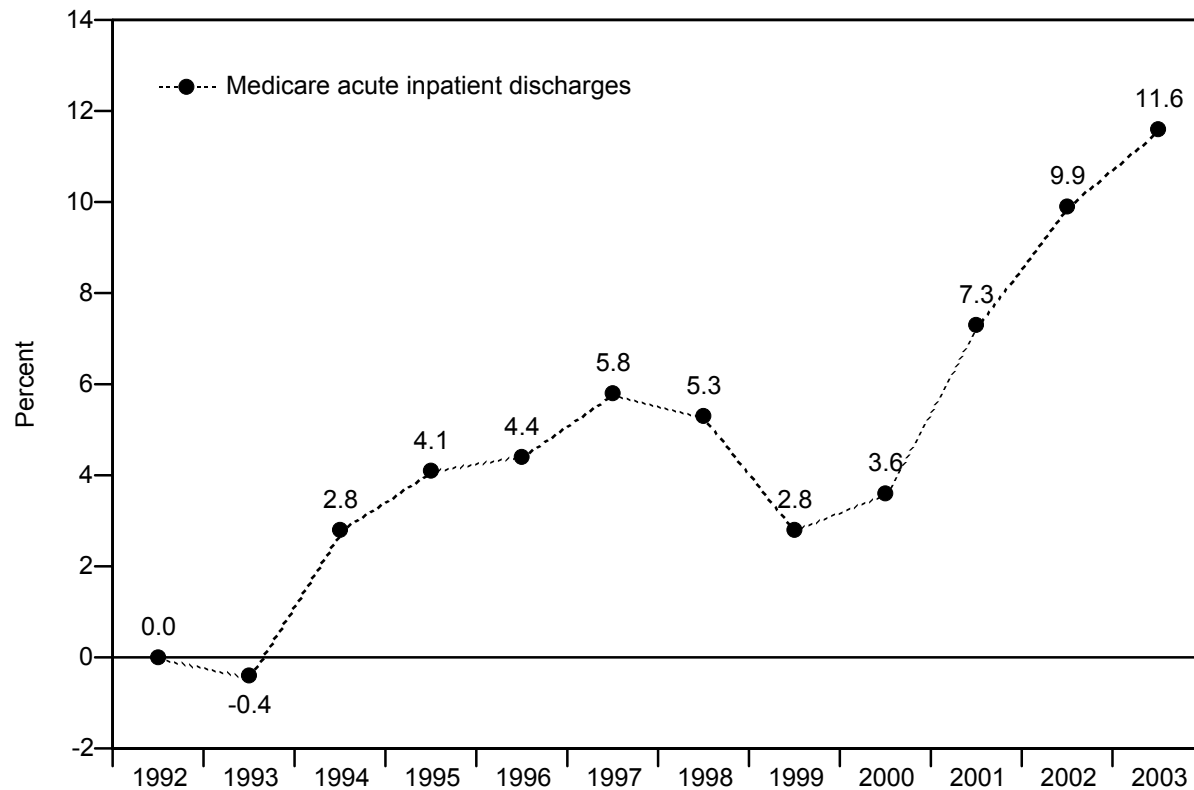
Hospital group	Hospitals		Medicare discharges	
	Number	Share of total	Number (thousands)	Share of total
All hospitals	3,845	100.0%	11,065	100.0%
Urban	2,608	67.8	9,263	83.7
Rural	1,237	32.2	1,802	16.3
Large urban	1,400	36.6	4,922	44.6
Other urban	1,255	32.8	4,422	40.0
Rural referral	192	5.0	666	6.0
Sole community	424	11.1	456	4.1
Small rural Medicare-dependent	188	4.9	173	1.6
Other rural < 50 beds	164	4.3	102	0.9
Other rural ≥ 50 beds	203	5.3	310	2.8
Voluntary	2,340	60.9	8,029	72.6
Proprietary	758	19.7	1,652	14.9
Government	742	19.3	1,383	12.5
Major teaching	292	7.6	1,638	14.8
Other teaching	806	21.0	3,869	35.0
Nonteaching	2,747	71.4	5,559	50.2

Note: Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system. Critical access hospitals, hospitals in Maryland, and hospitals paid through other payment systems (long-term care, rehabilitation, and psychiatric hospitals) are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least .25. Other teaching hospitals have a ratio of below .25.

Source: MedPAC analysis of impact file and Medicare cost report data (August 2004) from CMS.

- In 2003, 3,845 hospitals provided 11.1 million discharges under Medicare's acute inpatient prospective payment system. These numbers exclude critical access, long-term, psychiatric, and rehabilitation facilities, as well as hospitals in Maryland, all of which are covered by different payment systems.
- Two-thirds of the hospitals are located in urban areas, and this proportion has grown substantially in recent years as many rural facilities converted to critical access hospitals (see Chart 8-27). Urban hospitals are responsible for 84 percent of discharges. About 61 percent of hospitals are voluntary (non-profit, non-government) and provide 73 percent of discharges. Major teaching hospitals compose 8 percent of the hospitals and provide 15 percent of the care. About 21 percent of hospitals are covered by special payment provisions intended to help rural facilities that do not become critical access hospitals (rural referral, sole community, and small rural Medicare-dependent hospitals), and these facilities provide 12 percent of the discharges.

Chart 8-4. Cumulative percentage change in Medicare acute inpatient PPS discharges, 1992–2003

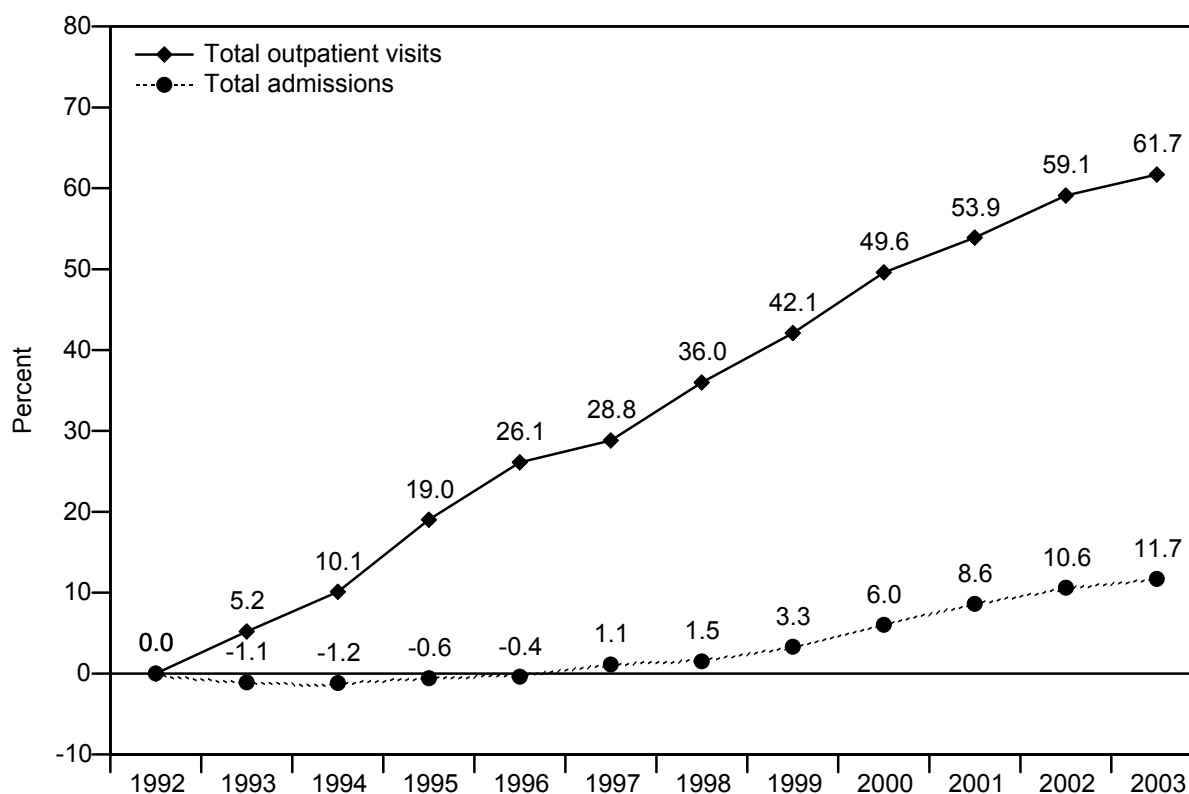


Note: Cumulative change is the total percentage increase from 1992 through year indicated. Data are Medicare discharges from approximately 3,800 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAR data from CMS.

- In 2003, there were 11.9 million discharges covered by the acute inpatient prospective payment system.
- Medicare discharges covered by the acute inpatient prospective payment system increased 11.6 percent from 1992 to 2003. Discharges grew 6.2 percent from 1993 to 1997, followed by a decline of 3.0 percent from 1997 to 1999 as beneficiaries enrolled in managed care. Discharges then grew 8.8 percent from 1999 to 2003, in part reflecting increasing fee-for-service enrollment, as enrollment in Medicare managed care declined.

Chart 8-5. Cumulative change in total admissions and total outpatient visits, 1992–2003

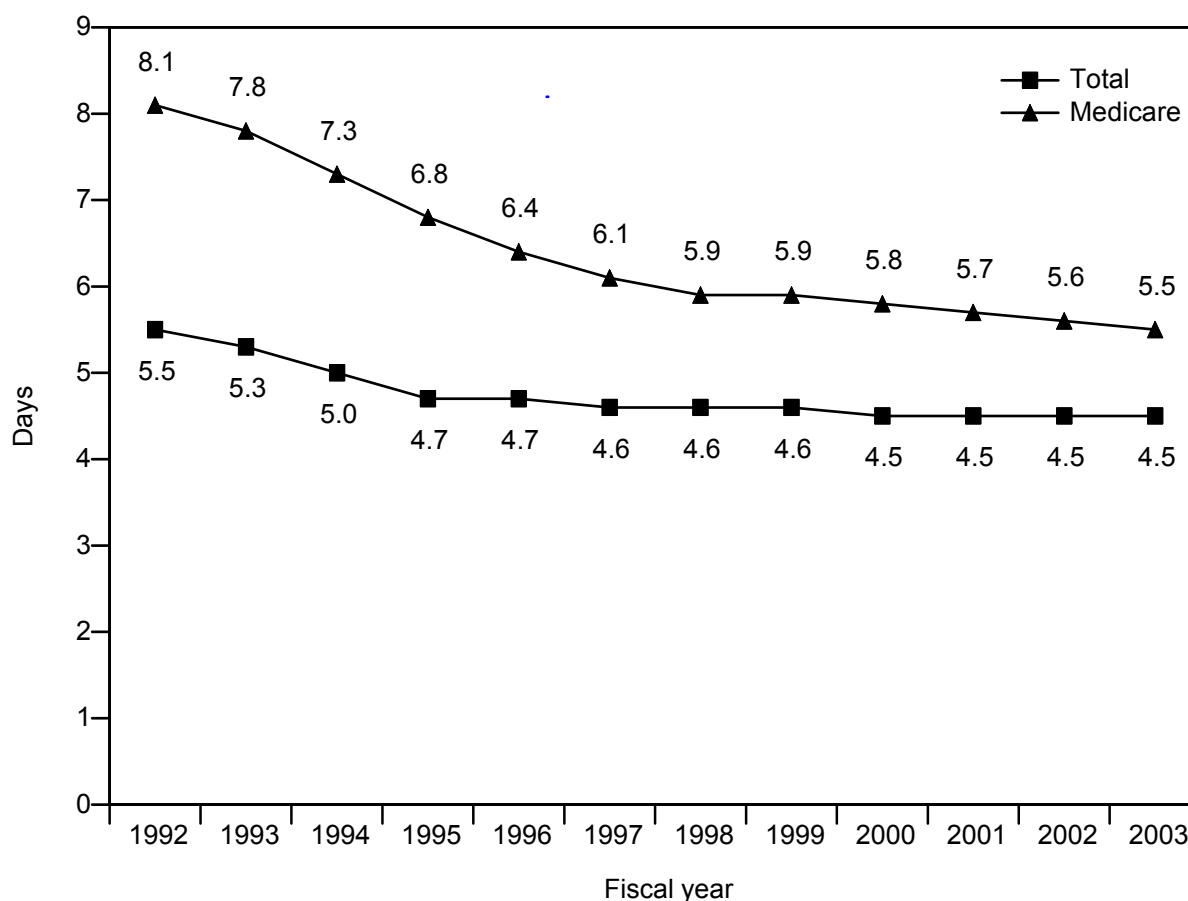


Note: Cumulative change is the total percent increase from 1992 through the year indicated. Data are admissions to and outpatient visits at approximately 5,000 community hospitals, excluding nursing home units.

Source: American Hospital Association annual survey of hospitals.

- Hospital outpatient service use has grown much more rapidly than inpatient service use. Total hospital outpatient visits increased 62 percent from 1992 to 2003, with increases exceeding 4 percent in every year except 1997 and 2003. Total admissions grew more slowly than outpatient visits, increasing just 12 percent from 1992 to 2003—about 1 percent a year on average.
- There were 571 million outpatient visits and 35 million admissions to community hospitals in 2003.

Chart 8-6. Trends in Medicare and total hospital length of stay, 1992–2003

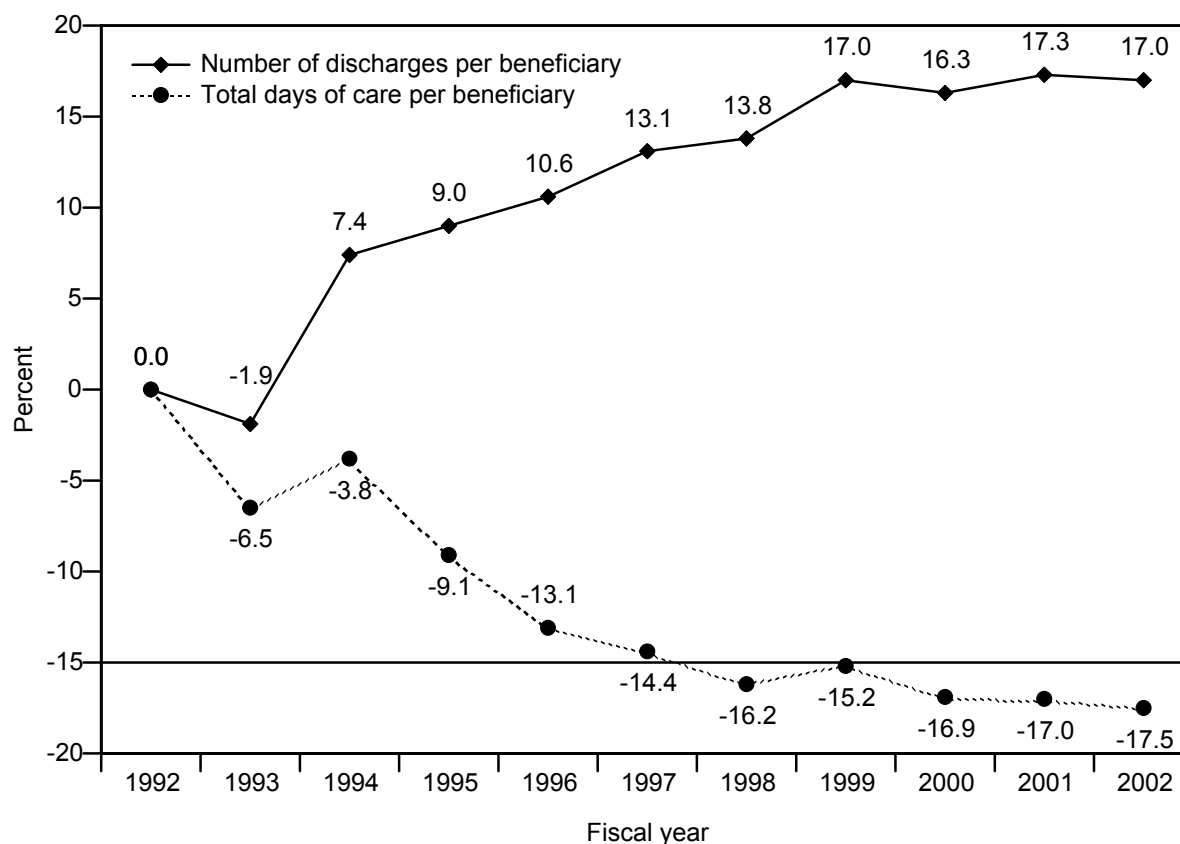


Note: Length of stay is calculated from admissions or discharges and patient days for approximately 3,800 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Length of stay for all hospital admissions fell 18 percent from 5.5 days in 1992 to 4.5 days in 2003, dropping at an average annual rate of 3.3 percent from 1992 to 1997 and 0.5 percent from 1997 to 2003.
- Length of stay for Medicare inpatients fell by 32 percent from 8.1 days in 1992 to 5.5 days in 2003, dropping at an average annual rate of 4.8 percent from 1992 to 1997 and 2.0 percent from 1997 to 2003.

Chart 8-7. Cumulative change in Medicare inpatient days per beneficiary and discharges per beneficiary, 1992–2002



Note: Cumulative change is the total percent increase from 1992 through the year indicated. Data are short-stay hospital Medicare patient days and discharges. Rate is per beneficiary enrolled in Part A. Beginning with 1994 data, the statistics do not reflect managed care enrollment.

Source: MedPAC analysis of data from CMS.

- While discharges per beneficiary have increased, length of stay has fallen. Medicare hospital use rates increased from 1992 to 2002, with 17.0 percent more hospital discharges per enrollee at the end of the period. However, declining length of stay led to 17.5 percent fewer days of inpatient care for each enrollee in 2002 compared to 1992.
- There were 365 Medicare hospital discharges and 2,158 patient days per 1,000 beneficiaries enrolled in Part A in fiscal year 2002.
- Beginning in 1994, the number of beneficiaries excludes managed care enrollees, increasing the rate per 1,000 beneficiaries enrolled in Part A (see Chart 13-2).

Chart 8-8. Simulated Medicare inpatient payments, by component and hospital group, reflecting 2005 payment policy under the MMA

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital ¹	
All hospitals	81.8%	5.0%	7.4%	3.9%	1.8%	\$99,406
Urban	82.0	5.6	7.7	4.3	0.3	86,846
Rural	80.8	0.5	4.7	1.3	12.7	12,560
Large urban	80.2	6.8	8.5	4.4	0.1	48,338
Other urban	84.3	4.1	6.8	4.2	0.6	39,036
Rural referral	83.3	1.2	5.7	2.0	7.8	5,067
Sole community	66.9	0.0	1.9	0.5	30.7	3,635
Small rural Medicare-dependent	93.3	0.0	4.6	0.7	1.3	906
Other rural < 50 beds	91.9	0.0	6.5	0.8	0.9	532
Other rural ≥ 50 beds	90.9	0.1	6.7	1.8	0.4	1,791
Voluntary	82.8	5.4	6.4	3.9	1.4	73,213
Proprietary	83.3	1.6	9.6	4.1	1.3	13,655
Government	74.4	6.3	10.4	4.2	4.7	12,534
Major teaching	67.5	16.6	10.2	5.5	0.1	21,783
Other teaching	84.5	3.7	7.2	3.9	0.5	35,540
Nonteaching	87.0	0.0	6.0	3.1	3.9	42,083

Note: MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003). IME (indirect medical education). DSH (disproportionate share). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Critical access hospitals, hospitals in Maryland, and hospitals paid through other payment systems (long-term care, rehabilitation, and psychiatric hospitals) are excluded. Graduate medical education (GME) payments are also excluded. Simulated payments reflect 2005 payment rules (which encompass provisions of the MMA) applied to actual number of cases in 2003. Actual payments in 2005 will likely be higher than shown due to growth in number of cases.

¹Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- If the discharges hospitals covered by the acute inpatient prospective payment system furnished in 2003 had been paid for under 2005 payment policies (reflecting the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), then Medicare would have spent \$99 billion. This figure is less than actual Medicare spending on hospital care in 2005 because it does not reflect increases in admissions from 2003 to 2005 and because it excludes payments made to critical access, rehabilitation, psychiatric, and long-term facilities as well as hospitals in Maryland.
- Special payments, which include disproportionate share (DSH), indirect medical education (IME), outlier, and new technology add-ons as well as additional payments to rural hospitals through the sole community and Medicare-dependent programs, account for 18 percent of all inpatient payments. This proportion is slightly lower for urban than rural hospitals, although urban hospitals get most of their assistance from DSH, IME, and outlier payments while rural programs account for most of rural facilities' extra funds. Major teaching hospitals have the largest share of payments coming from special payments, about 33 percent.
- The increase in payments resulting from MMA provisions, along with other policy changes occurring between 2003 and 2005, are highlighted in Chart 8-17.

Chart 8-9. Composition of the hospital market basket

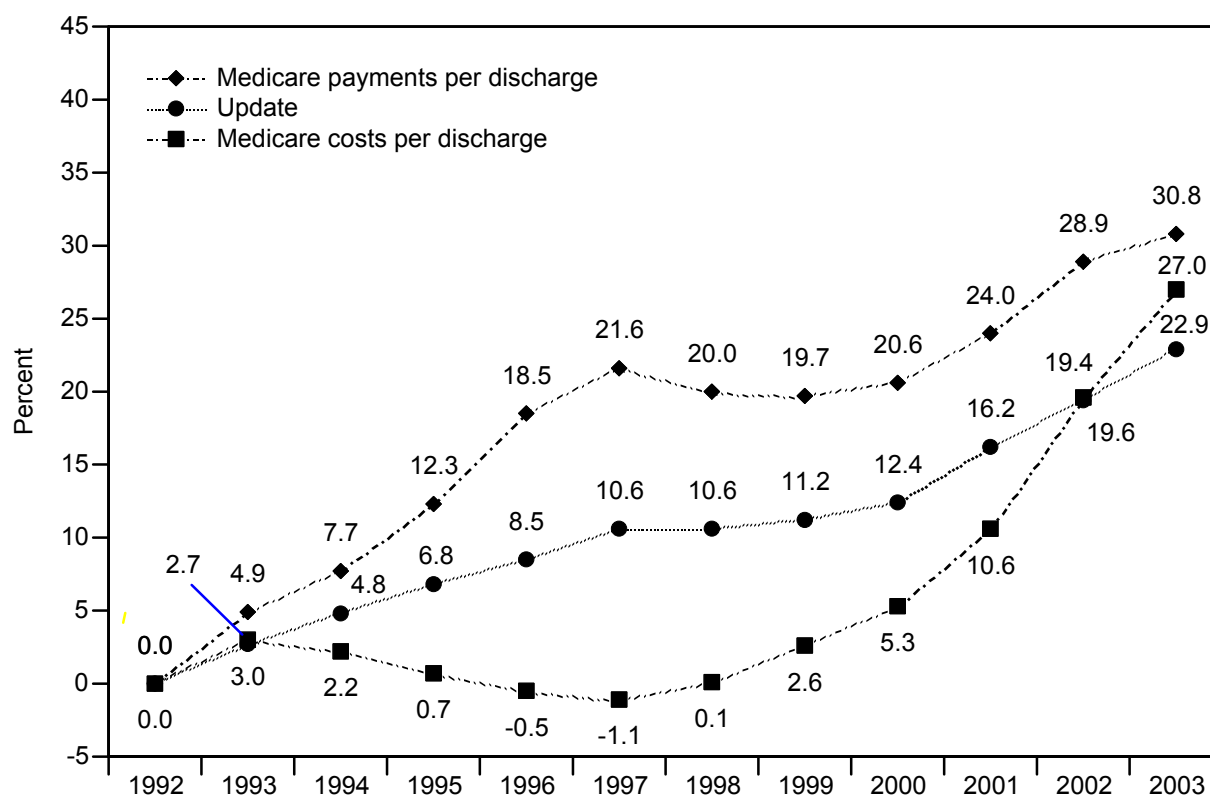
Input	Market basket weights (share of total)		Forecasted price change for 2006*
	FY 1997 based	FY 2002 based	
Total	100.0%	100.0%	3.4%
Compensation	61.7	60.0	3.6
Wages and salaries	50.7	48.2	3.5
Employee benefits	11.0	11.8	4.2
Professional fees	5.4	5.5	3.7
Utilities	1.4	1.3	2.0
Fuel, oil, and gasoline	0.3	0.2	2.6
Electricity	0.8	0.7	0.8
Water and sewerage	0.2	0.4	3.5
Professional liability insurance	0.8	1.6	6.3
All other	30.7	31.7	2.9
Other products	19.5	20.3	3.2
Pharmaceuticals	5.4	5.9	5.6
Direct purchase food	1.4	1.7	0.0
Contract service food	1.3	1.2	2.6
Chemicals	2.6	2.1	0.8
Blood and blood products**	0.9	N/A	N/A
Medical instruments	2.2	1.9	2.8
Photographic supplies	0.2	0.2	2.9
Rubber and plastics	1.7	2.0	4.6
Paper products	1.4	1.9	3.4
Apparel	0.6	0.4	0.2
Machinery and equipment	1.0	0.6	0.9
Miscellaneous products	1.0	2.6	1.7
All other services	11.2	11.3	2.3
Telephone services	0.4	0.5	1.2
Postage	0.9	1.3	1.0
All other: labor intensive	5.4	4.2	3.3
All other: non-labor intensive	4.5	5.3	2.0

Notes: FY (fiscal year). Totals may not sum to 100 due to rounding. Categories in bold face include subcategories not in bold face. CMS used FY 1997-based market basket weights for updating payments in FY 2005 and proposes to use FY 2002-based market basket weights in FY 2006. * Based on FY 2002 weights. ** Included in miscellaneous products in FY 2002-based weights.

Source: Federal Register, May 4, 2005, p. 23,387-23,389. Available at <http://www.gpoaccess.gov/fr/>. Market basket forecasts, CMS.

- CMS and the Congress use forecasts of the hospital market basket, a measure of the input prices paid by hospitals, to update payment rates. Over half of hospital operating costs—as measured by the market basket—are for labor expenses. These expenses are expected to increase by 3.6 percent in fiscal year 2006, more rapidly than growth in prices for other products and services. The forecast for the overall market basket is 3.4 percent.
- The hospital market basket reflects costs for hospitals paid under the acute inpatient prospective payment system. A CMS contractor prepares forecasts of price indexes that measure price changes for the market basket cost categories.
- For fiscal year 2006, CMS proposes to base the weights used in the market basket on 2002 data, rather than the 1997 data used in the market basket in fiscal year 2005. This change reduces the labor compensation share by 1.7 percentage points and increases the share of professional liability insurance by 0.8 percentage points. Effects on other cost categories are generally modest. The forecast for growth in fiscal year 2006 is 3.4 percent using either data source.

Chart 8-10. Cumulative change in Medicare acute inpatient PPS payments and costs per case, and PPS operating update, 1992–2003

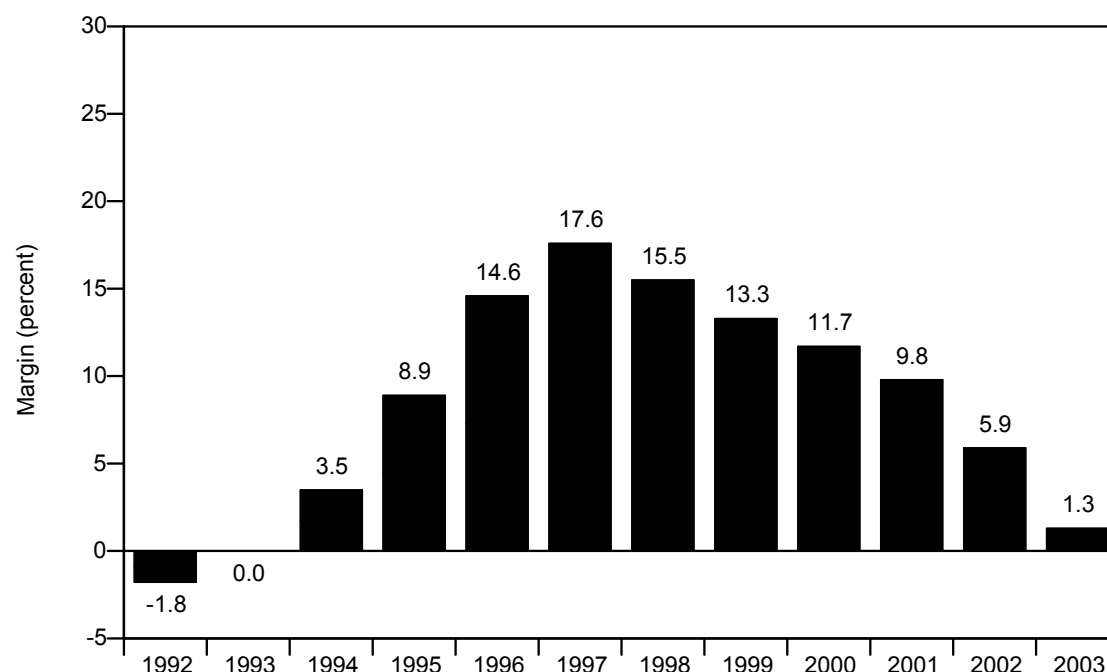


Note: PPS (prospective payment system). Cumulative change is the total percent increase from 1992 to the year indicated.

Source: MedPAC analysis of Medicare cost report data and market basket data from CMS.

- Medicare payments per discharge increased 30.8 percent from 1992 to 2003, significantly more than the rise in hospitals' costs per discharge (27.0 percent). The hospital market basket grew 39.7 percent over the period. The hospital update grew 22.9 percent.
- From 1993 through 1997, hospitals' payment increases exceeded the updates—due mostly to increases in case mix. Hospital costs grew more slowly than the market basket before 2001 primarily due to reduced length of stay. The gap between payments and costs increased from 1992 through 1997. From 1993 to 1997, Medicare payments per discharge grew more quickly than Medicare costs per discharge—costs declined by 4 percent while payments grew by 16 percent. From 1997 to 2003, the trend reversed.

Chart 8-11. Medicare acute inpatient PPS margin, 1992–2003

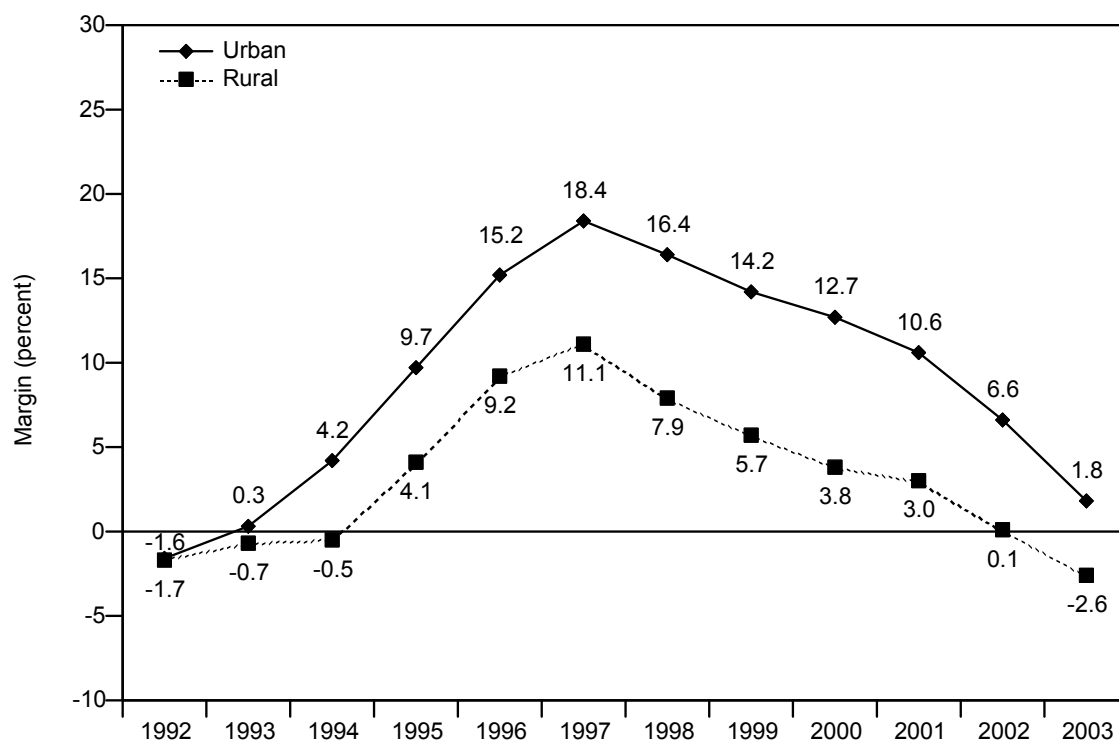


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- Medicare's acute inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs for measuring the relationship between payments and costs without the influence of how overhead costs are allocated.
- The Medicare inpatient margin increased steadily from 1992 through 1997, from a low of –1.8 percent to a record high of 17.6 percent. After implementation of the Balanced Budget Act of 1997, inpatient margins fell. In 2003, the margin was 1.3 percent.
- Medicare inpatient margins vary widely. In 2003, one quarter of hospitals had Medicare inpatient margins that were 10.7 percent or higher, and another quarter had margins that were –14.2 percent or lower. Between 1997 and 2003, this difference between the top and bottom quarter widened from 19 percent to 25 percent. About 48 percent of hospitals treating 49 percent of Medicare cases had positive inpatient Medicare margins in 2003.

Chart 8-12. Medicare acute inpatient PPS margins, by urban and rural location, 1992–2003

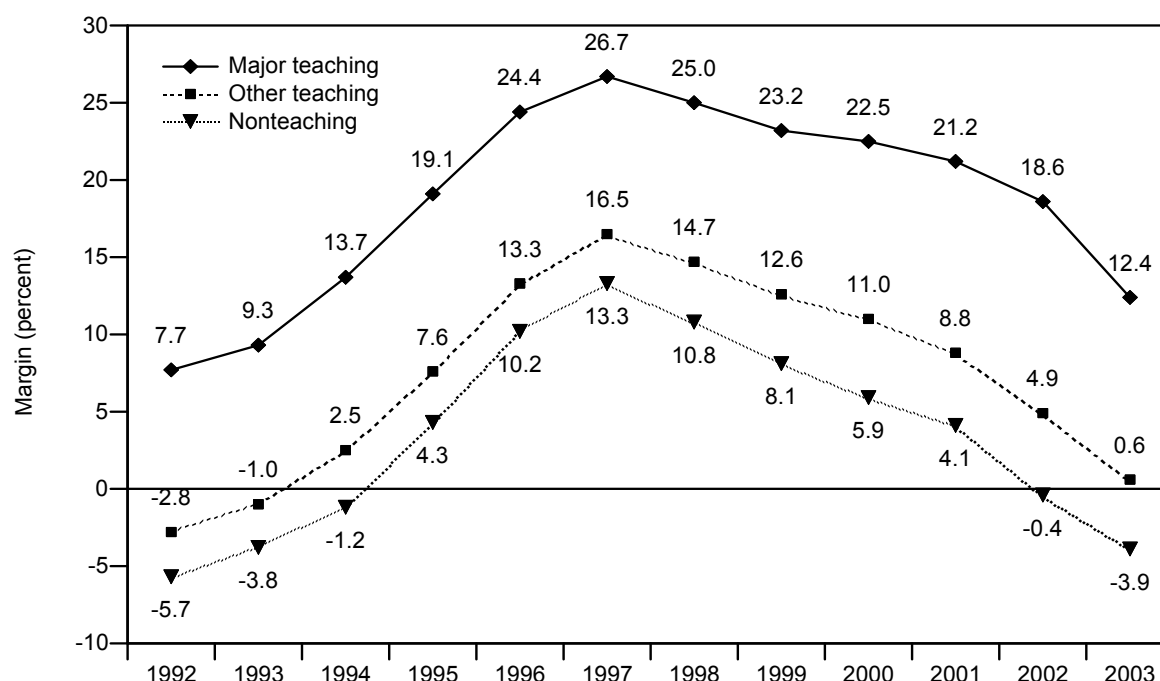


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- Medicare inpatient margins have consistently been higher for urban hospitals than for rural hospitals. A large part of this difference in financial performance can be explained by disproportionate share and indirect medical education adjustments that go primarily to urban hospitals.
- The gap between urban and rural hospitals' inpatient margins grew between 1992 and 2000. One factor in this widening divergence is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 through 2003, this difference narrowed, as payment policies that increased payments to rural hospitals were implemented. This difference may narrow further as policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals go into effect (see Chart 8-17).

Chart 8-13. Medicare acute inpatient PPS margins, by teaching status, 1992–2003

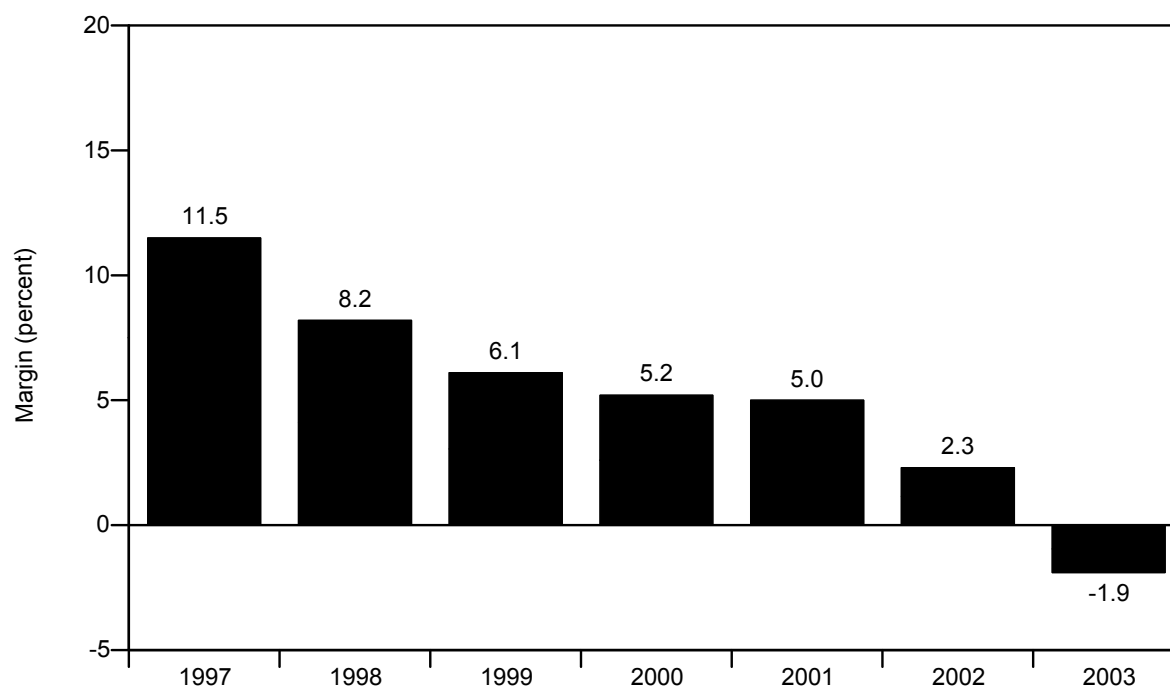


Note: PPS (prospective payment system). Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- Major teaching hospitals have consistently had higher inpatient PPS margins than other teaching hospitals and nonteaching hospitals. Major and other teaching hospitals' better financial performance is due largely to the additional payments they receive from the indirect medical education and disproportionate share adjustments.
- Margins rose substantially for all groups through 1997, peaking at 26.7 percent for major teaching hospitals and 13.3 percent for nonteaching hospitals. Since then, inpatient margins have fallen less for major teaching hospitals than for nonteaching hospitals, dropping 14.3 and 17.2 percentage points, respectively, primarily reflecting lower growth in per case costs for major teaching hospitals. The larger drop in the Medicare inpatient margin for major teaching hospitals in 2003 is primarily due to the indirect medical education payment dropping that year.

Chart 8-14. Overall Medicare margin, 1997–2003

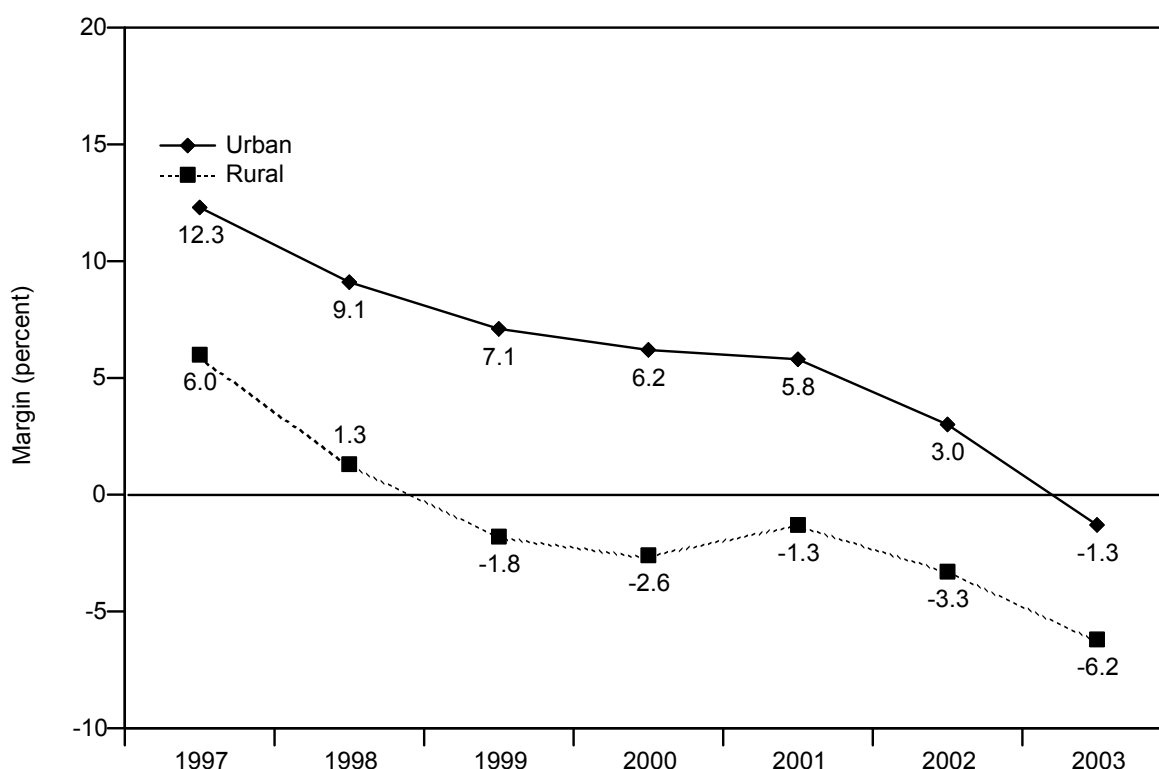


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health, and inpatient psychiatric and rehabilitative services, as well as graduate medical education and bad debts. The overall margin is available only since 1997, but it follows a trend similar to that of the inpatient margin.
- The overall margin is lower than the inpatient margin, which may be influenced by how hospitals allocate overhead costs. Only by combining data for all major services can we estimate Medicare costs for measuring the relationship between payments and costs without the influence of how overhead costs are allocated.
- The overall Medicare margin peaked in 1997 at 11.5 percent. In fiscal year 2003, it was -1.9 percent.
- In 2003, one quarter of hospitals had overall Medicare margins of 5.6 or higher, and another quarter had overall margins of -14.7 percent or lower. Between 1997 and 2003, the difference in performance between the top and bottom quartile widened from 14 percent to 20 percent. About 39 percent of hospitals had positive overall Medicare margins in 2003, accounting for 41 percent of Medicare inpatient discharges.

Chart 8-15. Overall Medicare margins, by urban and rural location, 1997–2003

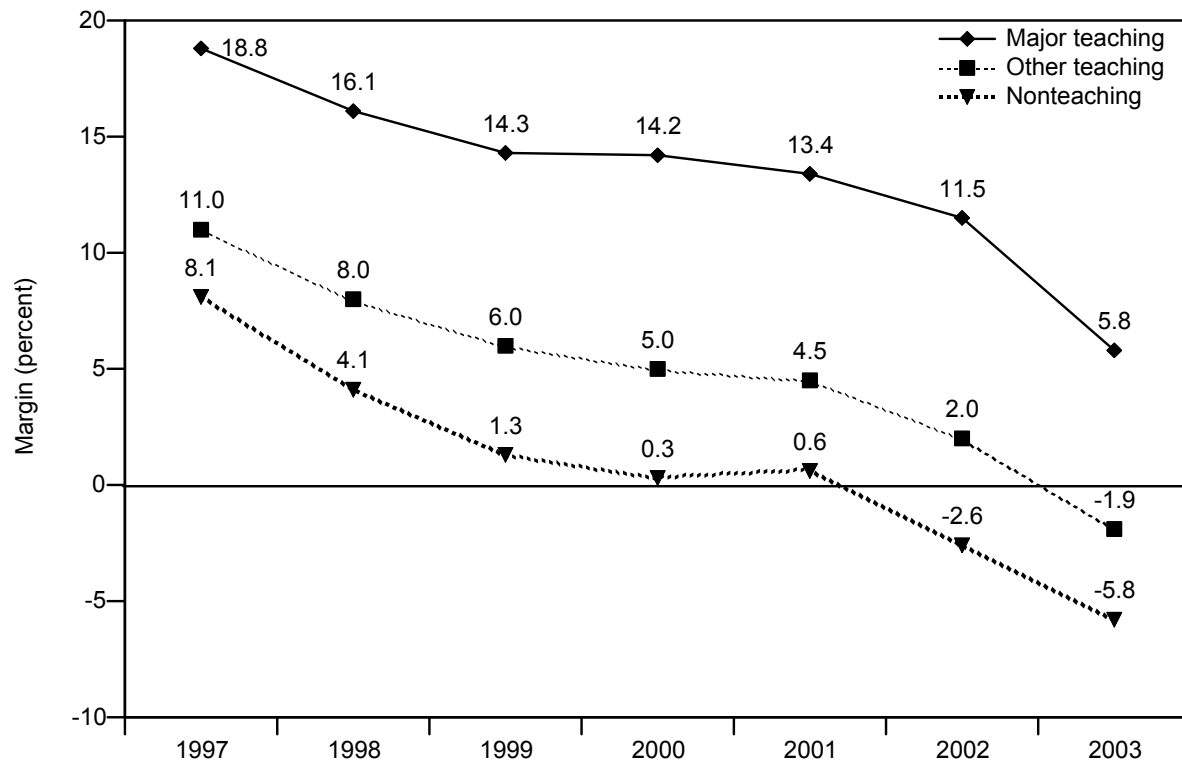


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1996 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- As with inpatient margins, overall Medicare margins have been consistently higher for urban hospitals than for rural hospitals.
- The difference in margins between the two groups grew between 1997 and 1999 but has since narrowed. In 1997, the overall margin for urban hospitals was 12.3 percent, compared with 6.0 percent for rural hospitals. In 2003, the overall margin for urban hospitals was –1.3 percent, compared with –6.2 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals should further narrow the difference in overall Medicare margins between urban and rural hospitals (see Chart 8-17).
- A large part of the difference in financial performance between urban and rural hospitals is attributable to urban hospitals receiving more disproportionate share and indirect medical education payments.

Chart 8-16. Overall Medicare margins, by teaching status, 1997–2003



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins includes the costs and payment of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- Major teaching hospitals consistently have had higher overall Medicare margins than other teaching hospitals and nonteaching hospitals primarily because of the additional payments they receive through the indirect medical education and disproportionate share adjustments under the acute inpatient payment system.
- In 2003, overall Medicare margins for major teaching hospitals were 5.8 percent, compared with –1.9 percent for other teaching and –5.8 percent for nonteaching hospitals.
- The difference in overall Medicare margins between major teaching hospitals and nonteaching hospitals grew from about 11 percentage points in 1997 to 14 percentage points in 2002, reflecting in part the lower cost growth of major teaching hospitals. The difference narrowed to 12 percentage points in 2003 as the IME adjustment was reduced.

Chart 8-17. Overall Medicare margins, actual through 2003 and simulated for 2005 to account for current policy, including MMA provisions

Hospital group	2000	2001	2002	2003	2005*
All hospitals	5.2%	5.0%	2.3%	-1.9%	-1.5%
Urban	6.2	5.8	3.0	-1.3	-1.3
Rural	-2.6	-1.3	-3.3	-6.2	-3.1
Major teaching	14.2	13.4	11.5	5.8	5.0
Other teaching	5.0	4.5	2.0	-1.9	-1.7
Nonteaching	0.3	0.6	-2.6	-5.8	-4.7

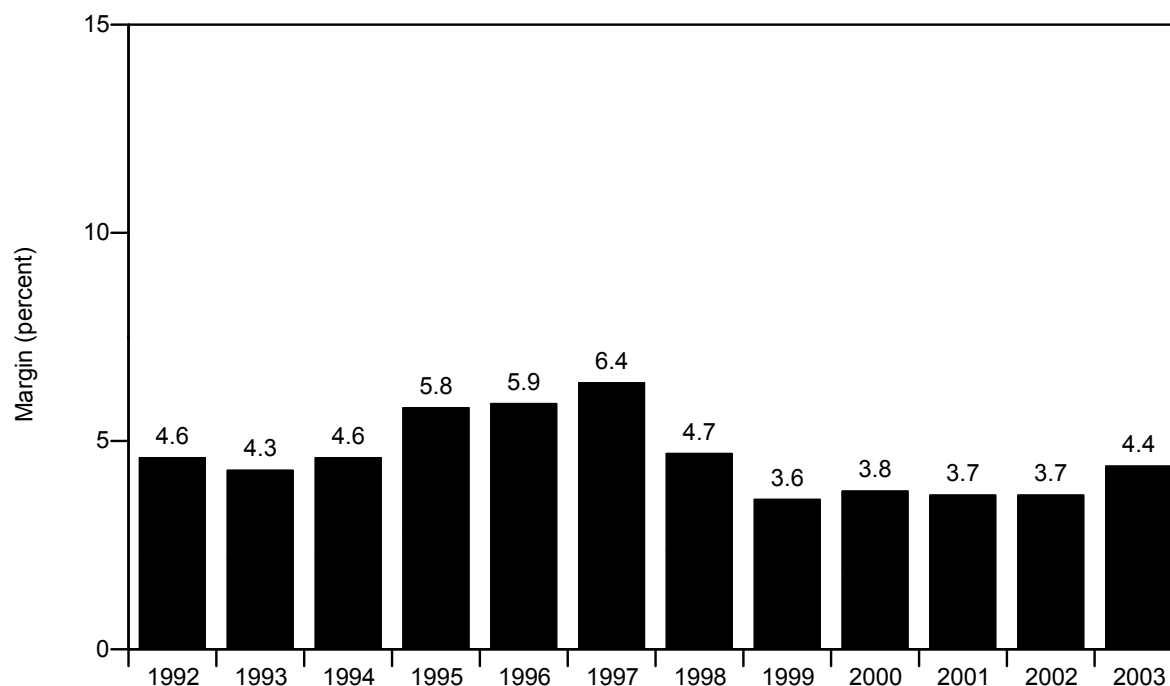
Note: MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003). Data are for hospitals covered by the Medicare acute inpatient prospective payment system in 2003. A margin is calculated as revenue minus costs divided by revenue; margins are based on Medicare-allowable costs. Overall Medicare margin covers acute inpatient, outpatient, hospital-based skilled nursing facility and home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and bad debts.

* 2005 margins are projections that reflect the effects of policy changes to be implemented in 2004 through 2006.

Source: MedPAC analysis of Medicare Cost Report files, MedPAR, and market basket file from CMS.

- The overall Medicare margin has trended downward since 2000, falling to -1.9 percent in 2003. The drop from 2002 resulted mostly from high cost growth, but payment policy changes also played a role.
- We estimate that the Medicare margin in 2005—reflecting 2006 payment policies—will increase slightly to -1.5 percent. The improvement in the margin in part reflects Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) policy changes that increased inpatient payment rates to many rural and some urban hospitals. Consequently, the gap in margin between urban and rural hospitals is expected to narrow between 2003 and 2005.

Chart 8-18. Hospital total margin, 1992–2003

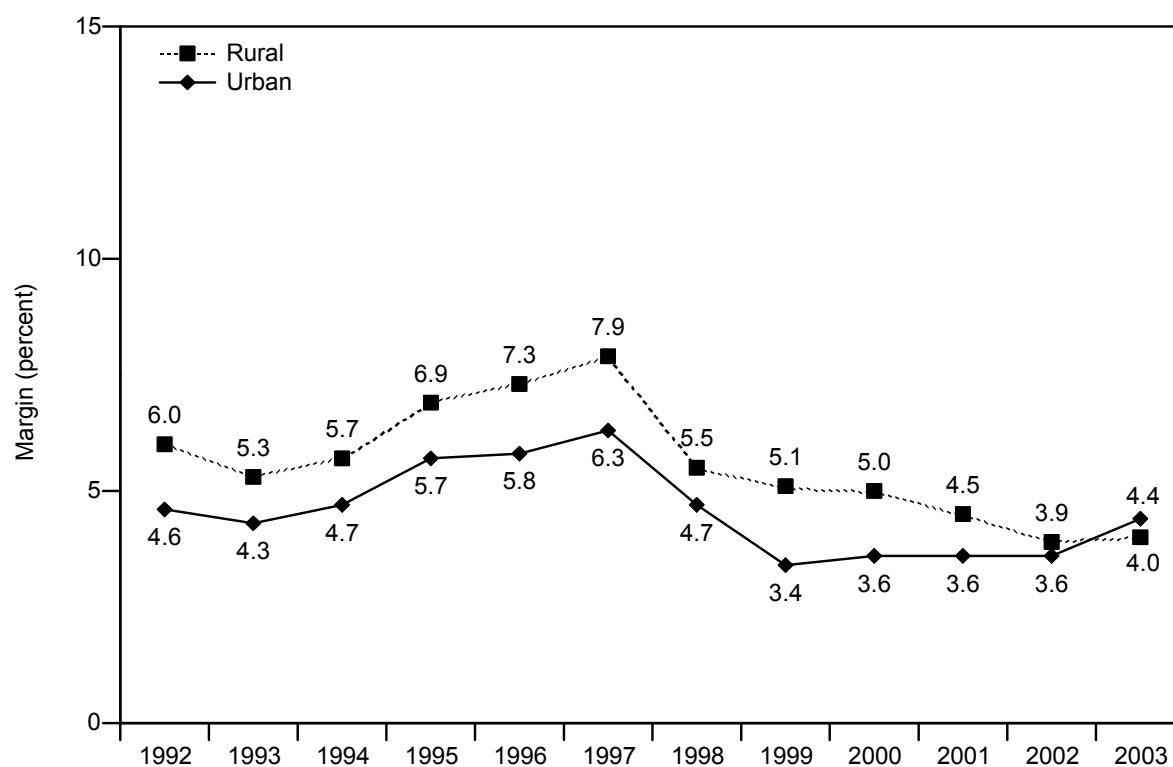


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.
- The total hospital margin gradually climbed from 4.3 percent in 1993 to 6.4 percent in 1997, before declining to between 3.6 percent and 3.8 percent in the 1999 to 2002 period. In 2003 the total hospital margin climbed to 4.4 percent, its highest level in five years.
- The fall in total margins from 1997 to 1999 reflected a drop in both Medicare and private payer margins. Medicare overall margins from 1997 through 2001 were higher than the total margin.
- In 2003, 69 percent of hospitals had positive total margins. These hospitals accounted for 76 percent of hospital discharges.

Chart 8-19. Total hospital margin, by urban and rural location, 1992–2003

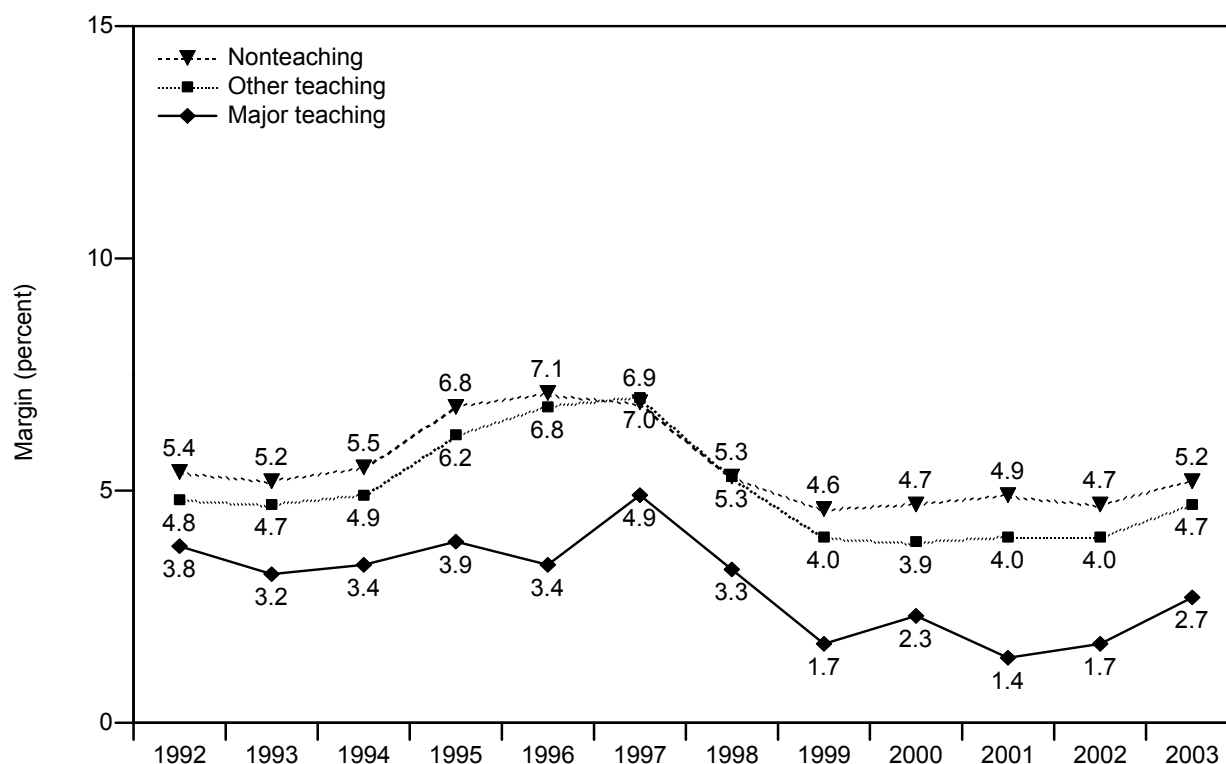


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus non-patient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- Until 2002, total margins for rural hospitals were consistently about 1 percentage point higher than total margins for urban hospitals. In 2003, for the first time, the total margin for urban hospitals, 4.4 percent, was higher than the margin for rural hospitals, 4.0 percent.

Chart 8-20. Total hospital margin, by teaching status, 1992–2003



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2004) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2003, the total margin for nonteaching hospitals stood at 5.2 percent compared with 2.7 percent for major teaching hospitals.
- Total margin for all three groups of providers in 2003 was at the highest level since 1998.

Chart 8-21. Hospitals with consistently negative overall Medicare margins tend to have above-average costs

Hospital characteristic	Negative Medicare margin hospitals	Positive Medicare margin hospitals	All hospitals
Hospitals in group (Share of total)	861 (29%)	1,106 (37%)	2,991 (100%)
Occupancy rate	46%	57%	51%
Annual change in length of stay (1994–2002)			
Medicare	–2.9%	–3.2%	–2.9%
All payers	–1.2	–1.4	–1.3
Average age of plant (years)	9.5	10.1	9.8
Medicare share of patient days	54%	48%	52%
Medicaid share of patient days	10	13	11
Standardized Medicare costs per discharge (2001)*	\$5,934	\$4,792	\$5,315
Annual change in Medicare costs per discharge (1999–2002)*	5.1%	4.8%	5.1%

Note: Median values shown. Data are for 2002 unless otherwise noted. The term consistently negative refers to hospitals with negative margins each year from 1999–2002.

*Standardized for differences in case mix and wage index.

Source: MedPAC analysis of impact file, MedPAR, and Medicare Cost Report files from CMS.

- Between 1999 and 2002, about 29 percent of hospitals had consistently negative overall Medicare margins while 37 percent had consistently positive overall Medicare margins.
- Less than 2 percent of hospitals had consistently negative Medicare and consistently negative total (all payer) margins.
- Hospitals with consistently negative margins tended to have lower occupancy rates (46%) and smaller declines in length of stay (–2.9 percent). The lower occupancy rates should translate into higher unit costs because fixed costs are spread over fewer units of output.
- Medicare standardized costs per discharge were substantially above average for the negative margin hospital group (\$5,934) and substantially below average for the positive margin group (\$4,792).
- The costs of positive margin hospitals increased more slowly than those of the negative margin hospitals over the four years analyzed, contributing to a widening gap in performance.

Chart 8-22. Hospitals with consistently negative overall Medicare margins have a poor competitive position in their market areas

Variable	Negative Medicare and total margin hospitals	Negative Medicare margin hospitals	Positive Medicare margin hospitals
Number of hospitals in group (Share of total)	55 (2%)	861 (29%)	1,106 (37%)
Occupancy rate (2002)			
For hospitals in group	42%	46%	57%
For other hospitals within 15 miles	57	55	59
Standardized Medicare costs per discharge (2001)*			
For hospitals in group	\$6,012	\$5,934	\$4,792
For other hospitals within 15 miles	5,630	5,654	5,182

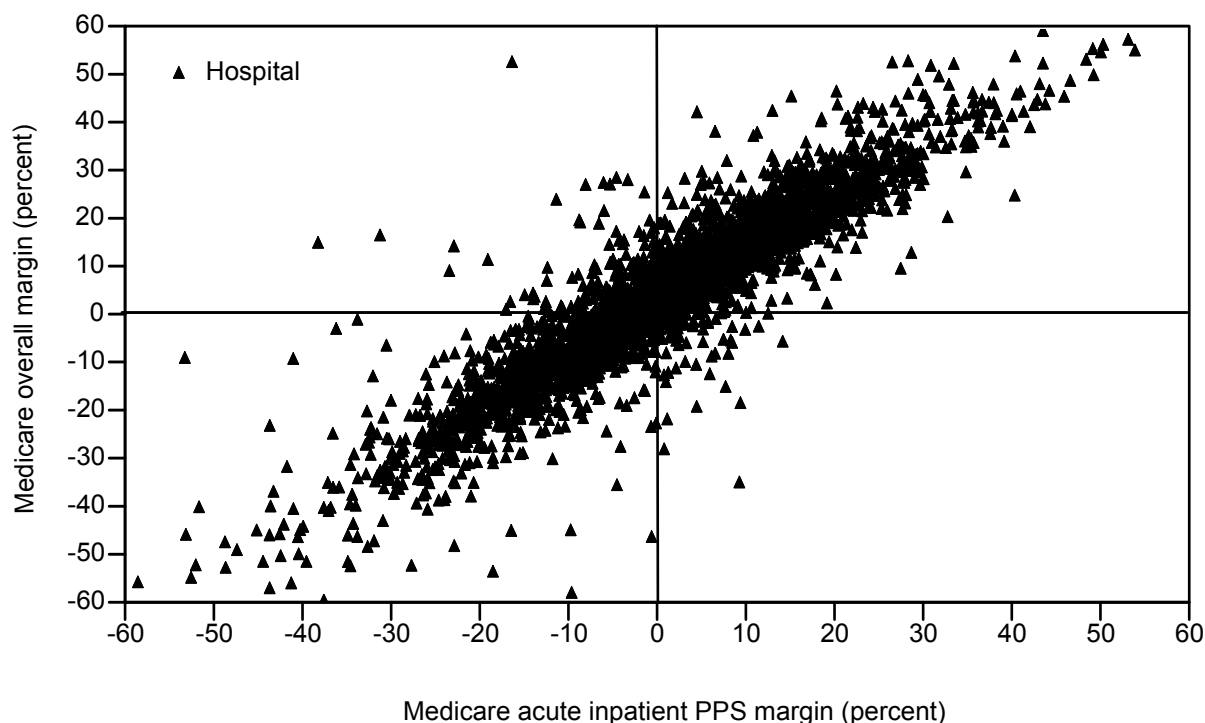
Note: Median values shown. The term consistently negative refers to hospitals with negative margins each year from 1999-2002.

* Standardized for differences in case mix and wage index.

Source: MedPAC analysis of impact file, MedPAR, and Medicare cost report data from CMS.

- Hospitals with consistently negative overall Medicare margins from 1999 through 2002 had poorer competitive positions in their market, with lower occupancy rates and higher costs per discharge than competitors within 15 miles.
- Hospitals with both negative overall Medicare margins and negative total margins had even lower occupancy rates (42 percent) than those with negative Medicare margins alone (46 percent). These hospitals only account for 2 percent of providers.
- Hospitals with consistently positive margins had close to the same occupancy rate and lower costs than their neighboring facilities.

Chart 8-23. Relationship of acute inpatient PPS and overall Medicare margins, 2001

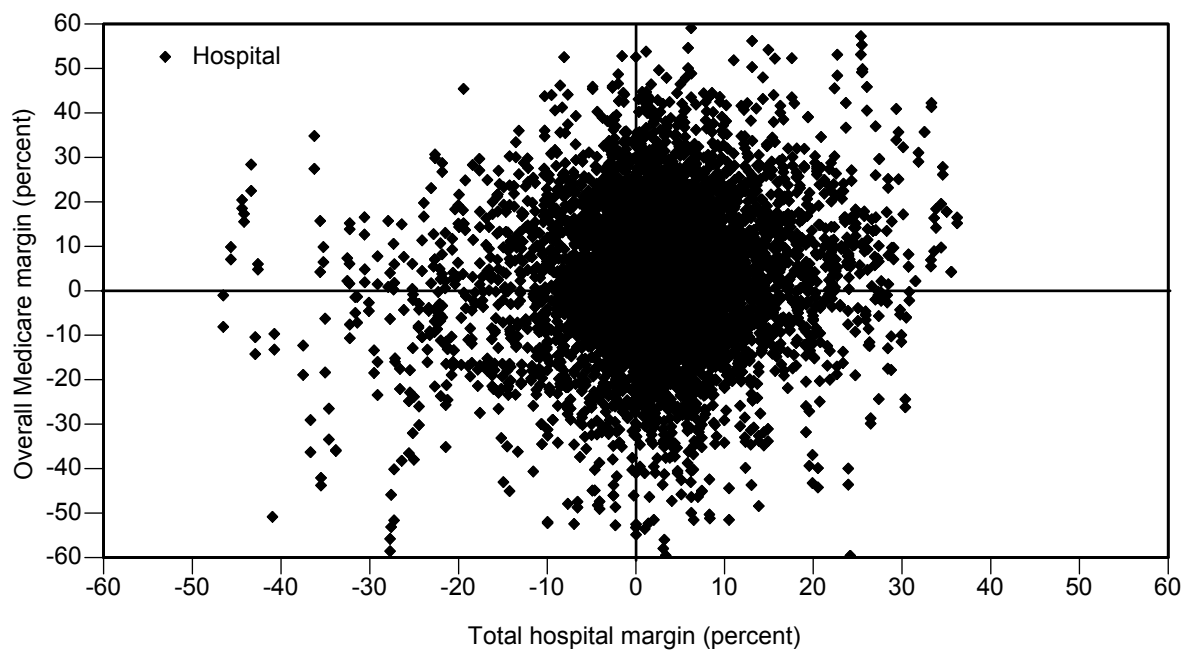


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. The Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- The Medicare inpatient and overall margins are strongly correlated ($R^2=0.883$) in part because inpatient payments make up about three-quarters of total Medicare payments.
- The Medicare overall margin tends to be lower than the inpatient margin, which may be overstated due to cost allocation bias.

Chart 8-24. Relationship of overall Medicare and total margins, 2001

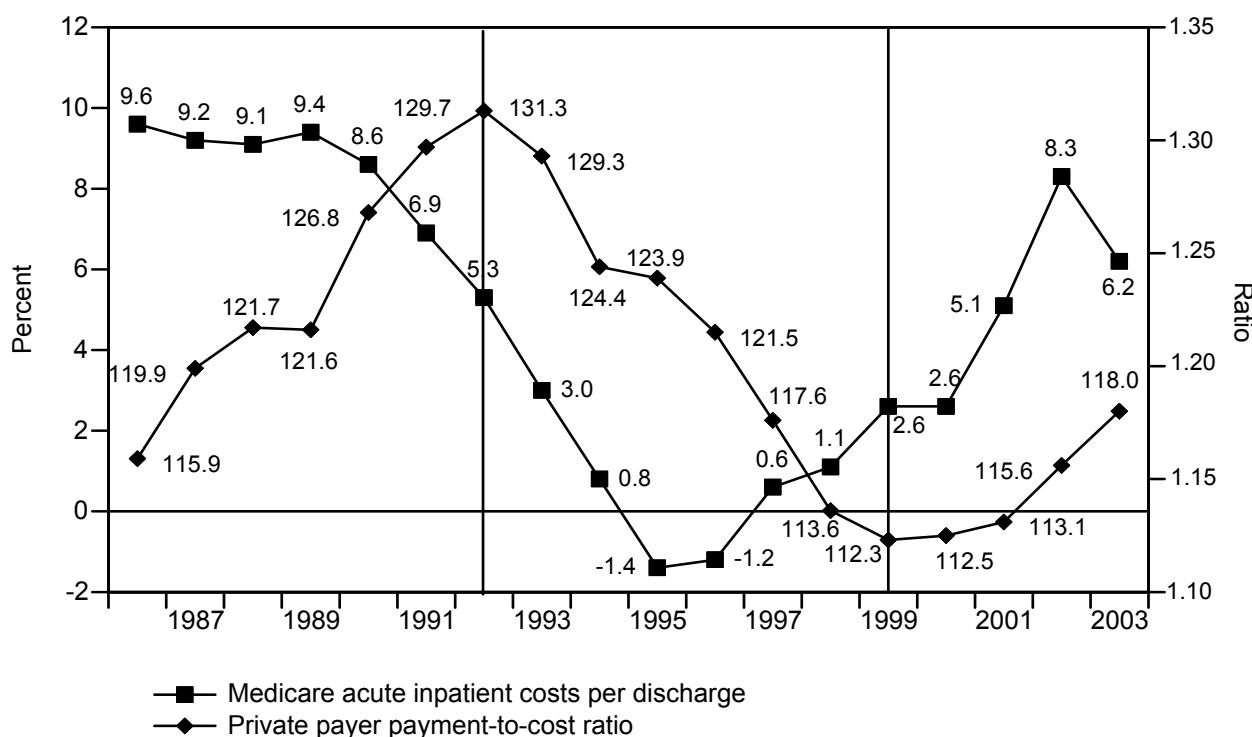


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2001 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Total margin includes all patient care services funded by all payers, plus nonpatient revenues.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- There is virtually no relationship between hospitals' overall Medicare margins and total (all payer) margins ($R^2=0.02$). That is, hospitals' performance in Medicare is not a good predictor of their performance across all payers and vice versa.
- Hospitals with negative Medicare margins and those with positive Medicare margins were almost equally likely to have positive total margins: 66 percent of hospitals with negative overall Medicare margins had positive total margins, while 73 percent of hospitals with positive Medicare margins had positive total margins.
- Hospitals in the upper right quadrant of the graph (38 percent) had positive overall Medicare margins and positive total margins in 2001, whereas hospitals in the lower left quadrant (16 percent) had negative overall Medicare margins and negative total margins.

Chart 8-25. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1986–2003

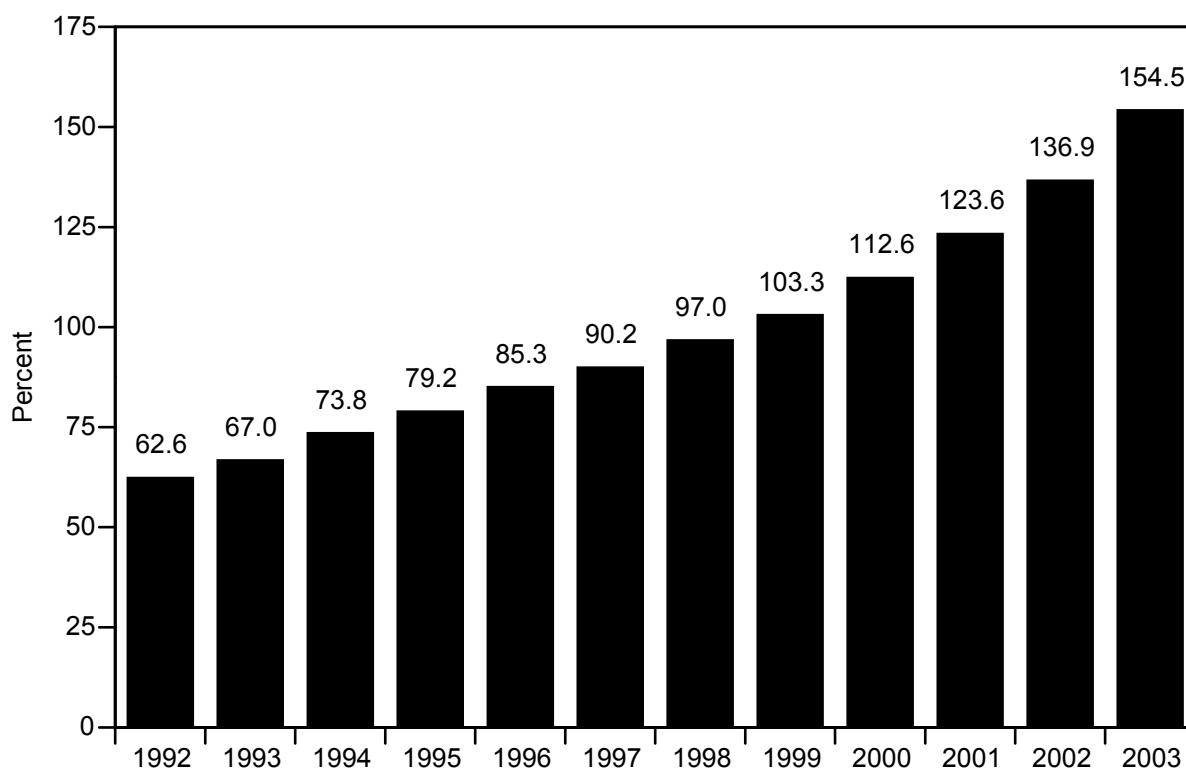


Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about 33 percent of observations). Most Medicare and Medicaid managed care patients are included in the private payer category.

Source: MedPAC analysis of Medicare Cost Report file from CMS and CMS's rules for the acute inpatient prospective payment system, and American Hospital Association Annual Survey of Hospitals.

- The pattern of growth in Medicare costs per discharge suggests that hospitals have responded to the incentives posed by the rise and fall of financial pressure from private payers over three periods.
- During the first period, 1986 through 1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year through these years, more than 3 percentage points a year above the increase in Medicare's market basket index.
- As HMOs and other private insurers exerted more pressure during the second period, 1993 through 1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to only 0.8 percent, which was more than 2 percentage points a year below the increase in the market basket.
- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio has again risen, and hospital cost growth has once again exceeded growth in the market basket by more than 3 percentage points a year.

Chart 8-26. Mark-up of charges over costs for all patient care services, 1992–2003

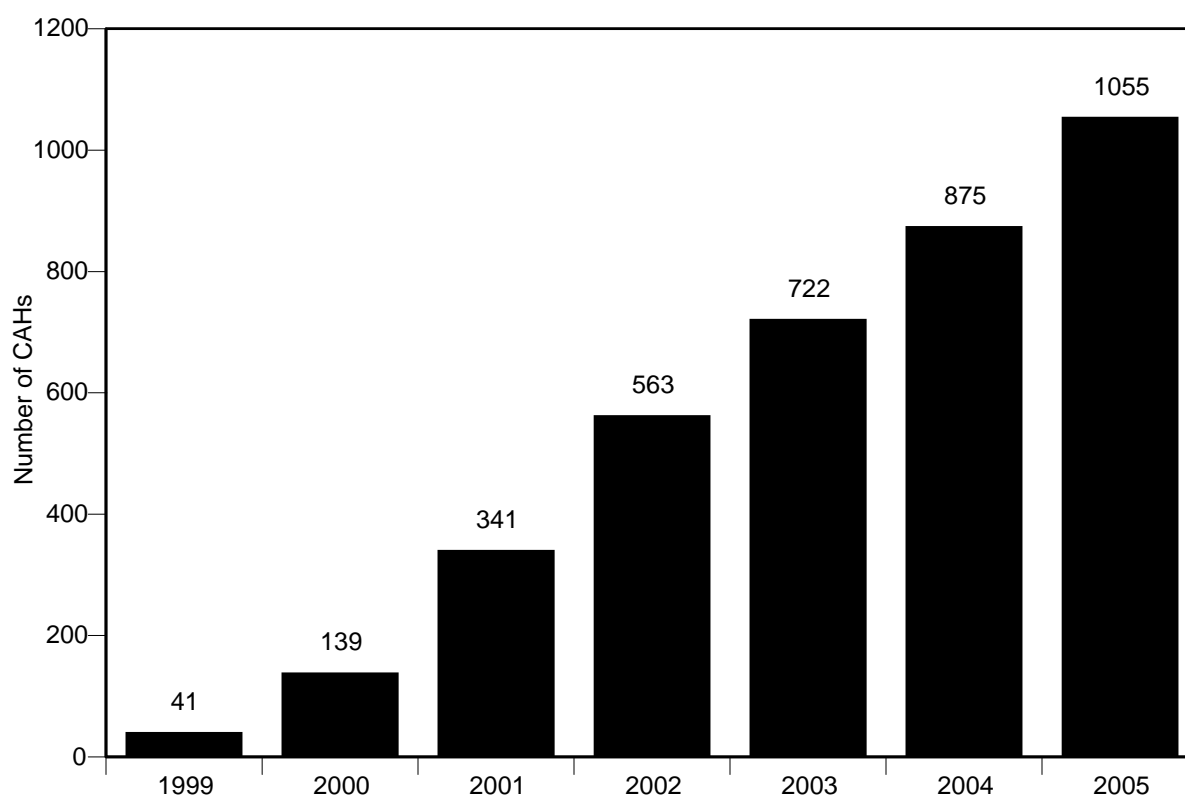


Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- From 1992 through 2003, hospitals' patient care costs (covering all services and all payers) increased 81 percent but their charges went up by 181 percent, more than twice as much. Consequently, the markup of charges over costs rose from 63 percent in 1992 to 155 percent in 2003. Charges are now two and a half times costs. In 2000 through 2003, the growth in mark-up—about 13 percentage points per year—was the largest since Medicare's acute inpatient PPS was implemented.
- Since few patients pay full charges, hospitals increasing their charges more than their costs may not have had much impact on their financial performance. Some are concerned, however, that uninsured individuals may be asked to pay full charges and may have collection proceedings applied against them. Faster growth rates for charges in recent years may have resulted from hospitals attempting to maximize revenue from private payers (who often structure their payments as a discount off charges) or their revenue from Medicare outlier payments.
- Additional information on this outlier payment issue can be found in the Medicare 2002 Hospital Outlier Payment Policy, available at http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf.

Chart 8-27. Change in the number of critical access hospitals, 1999–2005

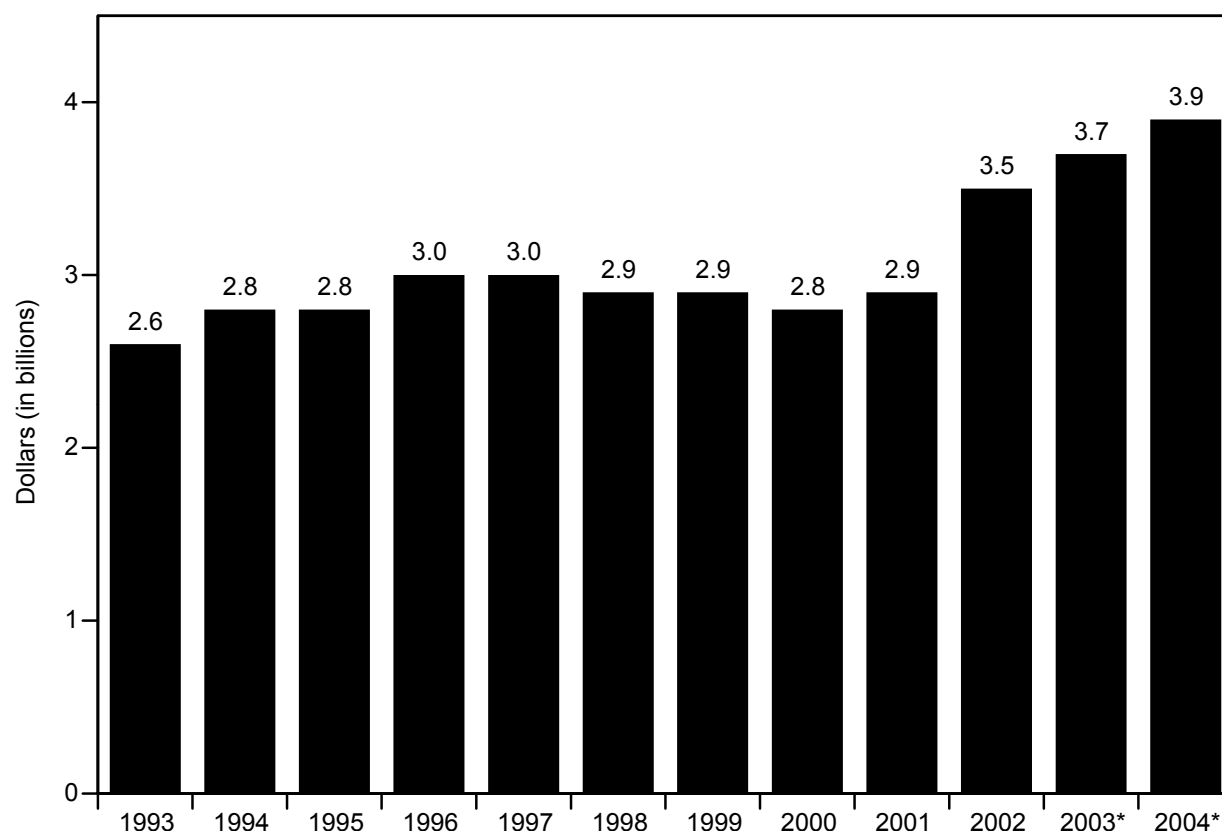


Note: Numbers of critical access hospitals (CAHs) are as of January 1 of each year.

Source: *The Rural Hospital Flexibility Tracking Project. Third-Year Findings*, February 2003, and additional data from CMS.

- The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs receive cost-based Medicare reimbursement for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.
- The number of CAHs has grown steadily over the last seven years, from 41 in 1999 to 1,055 at the beginning of 2005. By the end of May 2005, the number had grown to 1,112.

Chart 8-28. Medicare payments to inpatient psychiatric facilities, 1993–2004



Note: *Estimated spending.

Source: CMS, Office of the Actuary.

- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities increased 1 percent per year on average, from \$2.6 billion in 1993 to \$2.9 billion in 2001. CMS estimates that program spending will increase 10 percent per year for 2002–2004 to \$3.9 billion.
- Spending on inpatient psychiatric facilities makes up about 1 percent of Medicare's total spending.
- The inpatient psychiatric facility payment system started January 1, 2005. A description of the payment system can be found on the CMS website, available at <http://www.cms.hhs.gov/providers/ipfpps>.

Chart 8-29. Inpatient psychiatric facilities, 1996–2005

	1996	1998	2000	2002	2004	2005
Freestanding hospitals	642	627	582	503	478	468
Hospital-based units	1,445	1,489	1,487	1,437	1,389	1,334
Total	2,087	2,116	2,069	1,940	1,867	1,802

Source: Online Survey, Certification, and Reporting system from CMS.

- Inpatient psychiatric facilities—both freestanding hospitals and hospital-based units—provide acute hospital care to beneficiaries with mental illnesses or alcohol- and drug-related problems.
- From 1996 to 2005, the number of Medicare-certified freestanding hospitals decreased by 32 percent while the number of hospital-based units decreased by 8 percent, with a total loss of 14 percent of psychiatric facilities. In 2005, there are 1,802 inpatient psychiatric facilities—468 freestanding and 1,334 hospital-based units.

Web links. **Acute inpatient service**

Short-term hospitals

- Chapter 2A of the MedPAC March 2005 Report to the Congress provides additional detailed information on hospital margins.

http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02a.pdf

- Chapter 2A of the MedPAC March 2002 Report to the Congress provides information on the hospital market basket.

http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2A.pdf

- CMS also provides information on the hospital market basket.

<http://www.cms.gov/statistics/market-basket/pps-hospital.pdf>

- CMS published the acute inpatient PPS proposed rule in the May 4, 2005 Federal Register.

<http://www.gpoaccess.gov/index.html>

Specialty psychiatric facilities

- CMS provides information on the proposed inpatient prospective payment system.

<http://cms.hhs.gov/providers/ipfpps>

